

Facility Name & ID Number Burnham House# 0041327 Report Period Beginning: 10/01/04 Ending: 09/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,445</u>			<u>5,445</u>	13
14	TOTALS	<u>5,445</u>			<u>5,445</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.24%

D. How many bed-hold days during this year were paid by the Department?

306 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 4/1/96

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/01/95 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☒Tax Year: 12/31/05 Fiscal Year: 09/30/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Burnham House

0041327

Report Period Beginning: 10/01/04

Ending: 09/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	41,823	39	3,992	45,854		45,854		45,854		1
2	Food Purchase		26,969		26,969		26,969		26,969		2
3	Housekeeping	27,349	7,883		35,232		35,232	40	35,272		3
4	Laundry	23,930	1,365		25,295		25,295		25,295		4
5	Heat and Other Utilities			19,209	19,209		19,209	1,650	20,859		5
6	Maintenance			23,471	23,471		23,471	7,954	31,425		6
7	Other (specify):*										7
8	TOTAL General Services	93,102	36,256	46,672	176,030		176,030	9,644	185,674		8
	B. Health Care and Programs										
9	Medical Director		8,974	5,400	14,374		14,374		14,374		9
10	Nursing and Medical Records	135,676	22	41,334	177,032		177,032	1,609	178,641		10
10a	Therapy										10a
11	Activities	20,512	1,938		22,450		22,450		22,450		11
12	Social Services			2,450	2,450		2,450	(2,450)			12
13	CNA Training	9,504			9,504		9,504		9,504		13
14	Program Transportation			3,140	3,140		3,140		3,140		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	165,692	10,934	52,324	228,950		228,950	(841)	228,109		16
	C. General Administration										
17	Administrative	40,247		102,766	143,013		143,013	(76,665)	66,348		17
18	Directors Fees										18
19	Professional Services			9,921	9,921		9,921	2,692	12,613		19
20	Dues, Fees, Subscriptions & Promotions			3,389	3,389		3,389	374	3,763		20
21	Clerical & General Office Expenses	13,674	2,252	12,737	28,663		28,663	12,924	41,587		21
22	Employee Benefits & Payroll Taxes			60,288	60,288		60,288	14,832	75,120		22
23	Inservice Training & Education			588	588		588	236	824		23
24	Travel and Seminar							2,335	2,335		24
25	Other Admin. Staff Transportation			1,346	1,346		1,346	2,132	3,478		25
26	Insurance-Prop.Liab.Malpractice			6,510	6,510		6,510	2,493	9,003		26
27	Other (specify):* IDPH Fine			6,500	6,500		6,500	(6,500)			27
28	TOTAL General Administration	53,921	2,252	204,045	260,218		260,218	(45,147)	215,071		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	312,715	49,442	303,041	665,198		665,198	(36,344)	628,854		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Burnham House

#0041327

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			14,194	14,194		14,194	13,350	27,544			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			713	713		713	8,100	8,813			32
33	Real Estate Taxes			20,309	20,309		20,309	2,085	22,394			33
34	Rent-Facility & Grounds			92,760	92,760		92,760		92,760			34
35	Rent-Equipment & Vehicles			300	300		300	452	752			35
36	Other (specify):*											36
37	TOTAL Ownership			128,276	128,276		128,276	23,987	152,263			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,310	54,310		54,310		54,310			42
43	Other (specify):* IL Repl Tax			3,350	3,350		3,350	(3,350)				43
44	TOTAL Special Cost Centers			57,660	57,660		57,660	(3,350)	54,310			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	312,715	49,442	488,977	851,134		851,134	(15,707)	835,427			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burnham House

0041327

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10/01/04

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09/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,500)	27-3		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,350)	43-4		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,850)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule Schedule VIII	(5,857)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (5,857)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (15,707)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Burnham House

ID# 0041327

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

09/30/05

[illegible]

Summary B

09/30/05

09/30/05

[illegible]

Facility Name & ID Number Burnham House# 0041327

Report Period Beginning:

10/01/04

Ending:

09/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule VII C		See Attached Schedule		Health Services Cons.	Champaign, IL	Consulting
				Cobblestone Rehab.	Champaign, IL	Therapy
				The Residential Develo	Champaign, IL	Long Term Care
				Developmental Found.	Champaign, IL	Long Term Care
				MBD, LLC	Champaign, IL	Rental Real Estate
				P&L Rentals, LLC	Champaign, IL	Rental Real Estate

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See Schedule VIII	\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burnham House # 0041327 Report Period Beginning: 10/01/04 Ending: 09/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Alan Ryle	President	Administrative	48.55	All related party wages are allocations			Administrative	\$ 3,222	17-7	1
2	Lynn Ryle	Vice-President	Administrative	48.54	from HSC. See attached allocation			Administrative	1,277	17-7	2
3	Cathy Patton	Operating Director	Administrative	2.91	spreadsheet and explanation. These			Administrative	3,205	17-7	3
4					individuals receive no compensation from						4
5					entities other than HSC.						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 7,704		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burnham House# 0041327

Report Period Beginning:

10/01/04Ending: 09/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Health Services Consultants, Inc.Street Address P.O. Box 3037City / State / Zip Code Champaign, IL 61826Phone Number (217) 398-3754Fax Number (217) 3938-0944

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing	Reverse expenses for actual amounts paid and accrued to		\$	\$		(22,960)	1
2	12	Social	HSC for services provided in order to allocate HSC's					(2,450)	2
3	17	Administrative	actual expenses.					(102,766)	3
4	21	Clerical						(6,563)	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13	1	Dietary	Beds	400	207		16		13
14	2	Food Purchases	Beds	400	207		16		14
15	3	Housekeeping	Beds	400	207	992	16	40	15
16	5	Heat & Utilities	Beds	400	207	41,239	16	1,650	16
17	6	Maintenance	Beds	400	207	141,680	16	7,954	17
18	9	Medical Director	Beds	400	207		16		18
19	10	Nursing	Beds	400	207	262,309	16	24,569	19
20	11	Activities	Beds	400	207		16		20
21	12	Social	Beds	400	207		16		21
22	13	Nurse Training	Beds	400	207		16		22
23	14	Program Transportation	Beds	400	207		16		23
24	17	Administrative	Beds	400	207	479,307	16	25,951	24
25	TOTALS				\$ 925,527	\$ 757,014		\$ (74,575)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burnham House # 0041327 Report Period Beginning: 10/01/04 Ending: 09/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Health Services Consultants, Inc.
 Street Address P.O. Box 3037
 City / State / Zip Code Champaign, IL 61826
 Phone Number (217) 398-0754
 Fax Number (217) 398-0944

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18 Director Fees	Beds	400	207	\$	\$	16	\$	1
2	19 Professional Fees	Beds	400	207	67,292		16	2,692	2
3	20 Dues & Subscriptions	Beds	400	207	9,348		16	374	3
4	21 Clerical	Beds	400	207	450,880	335,463	16	19,417	4
5	22 P/R Taxes & Benefits	Beds	400	207	527,878		16	14,832	5
6	23 Inservice	Beds	400	207	5,908		16	236	6
7	24 Travel & Seminar	Beds	400	207	58,377		16	2,335	7
8	25 Administrative Transportation	Beds	400	207	53,288		16	2,132	8
9	26 Insurance	Beds	400	207	62,315		16	2,493	9
10	30 Depreciation	Beds	400	207	333,750		16	13,350	10
11	32 Interest	Beds	400	207	202,504		16	8,100	11
12	33 Real Estate Tax	Beds	400	207	52,134		16	2,085	12
13	34 Building Lease	Beds	400	207			16		13
14	35 Equipment Lease	Beds	400	207	11,294		16	452	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,760,495	\$ 1,092,477		\$ (6,077)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burnham House # 0041327 Report Period Beginning: 10/01/04 Ending: 09/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Specialized Developments, Ltd.
 Street Address P.O. Box 3037
 City / State / Zip Code Champaign, IL 61826
 Phone Number (217) 398-0754
 Fax Number (217) 398-0944

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>1</u> <u>Dietary</u>	<u>Beds</u>	<u>32</u>	<u>2</u>	\$	\$	<u>16</u>	\$	1
2	<u>2</u> <u>Food Purchase</u>	<u>Beds</u>	<u>32</u>	<u>2</u>			<u>16</u>		2
3	<u>9</u> <u>Medical Director</u>	<u>Beds</u>	<u>32</u>	<u>2</u>			<u>16</u>		3
4	<u>17</u> <u>Administrative</u>	<u>Beds</u>	<u>32</u>	<u>2</u>	<u>300</u>		<u>16</u>	<u>150</u>	4
5	<u>21</u> <u>Clerical & General Office</u>	<u>Beds</u>	<u>32</u>	<u>2</u>	<u>139</u>		<u>16</u>	<u>70</u>	5
6	<u>32</u> <u>Interest</u>	<u>Beds</u>	<u>32</u>	<u>2</u>			<u>16</u>		6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 439	\$		\$ 220	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$		\$			\$	1
2	Ford Credit		x	Vehicle	\$1,210.00	5/5/04	42,346	22,988	5/4/07	zero			2
3													3
4													4
5													5
	Working Capital												
6	Bussey Bank		X	Working Capital	N/A	N/A	N/A		N/A			713	6
7	Schedule VIII Allocations		X									8,100	7
8													8
9	TOTAL Facility Related				\$1,210.00		\$ 42,346	\$ 22,988				\$ 8,813	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$				\$	14
15	TOTALS (line 9+line14)						\$ 42,346	\$ 22,988				\$ 8,813	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Burnham House**# **0041327** Report Period Beginning: **10/01/04** Ending: **09/30/05****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2004 report.			\$	15,388 1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	19,907 2
3. Under or (over) accrual (line 2 minus line 1).			\$	4,519 3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	15,790 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	20,309 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2000	18,929	8	
	2001	20,406	9	
	2002	20,434	10	
	2003	20,259	11	
	2004	19,907	12	
\$21,053 (estimate 2004 tax) x 9/12 = \$15,790				
				FOR OHF USE ONLY
13 FROM R. E. TAX STATEMENT FOR 2004 \$				13
14 PLUS APPEAL COST FROM LINE 5 \$				14
15 LESS REFUND FROM LINE 6 \$				15
16 AMOUNT TO USE FOR RATE CALCULATION \$				16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burnham House COUNTY Will

FACILITY IDPH LICENSE NUMBER 0041327

CONTACT PERSON REGARDING THIS REPORT Sherry Newton

TELEPHONE (217) 398-0754 FAX #: (217) 398-0944

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>21-14-12-100-022-0010</u>	<u>Facility</u>	\$ <u>4,372.00</u>	\$ <u>2,186.00</u>
2. <u>21-14-12-100-001-0020</u>	<u>Facility</u>	\$ <u>35,441.00</u>	\$ <u>17,721.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. <u>Willow House is located on the</u>	_____	\$ _____	\$ _____
6. <u>same tract of land. 50% of the</u>	_____	\$ _____	\$ _____
7. <u>real estate tax bill is allocated to</u>	_____	\$ _____	\$ _____
8. <u>each home.</u>	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>39,813.00</u></u>	\$ <u><u>19,907.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

A. Square Feet:

5,200

B. General Construction Type:

Exterior Vinyl & Brick

Frame Wood

Number of Stories

1

C. Does the Operating Entity?

☐ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Burnham House

0041327

Report Period Beginning:

10/01/04

Ending:

09/30/05

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Doorknobs, Shower Heads		8/10/1998	726	27	27	27		196	9
10		Drywall Repair		9/1/1998	661	24	27	24		174	10
11		Alarm System Upgrade		10/22/1998	3,488	129	27	129		902	11
12		Alarm System Upgrade		3/24/1998	693	26	27	26		174	12
13		Protective Lower Wall Coverng		11/30/1999	2,983	110	27	110		634	13
14		Rebuild Hot Water System		2/16/2001	844	31	27.5	31		155	14
15		Furnace Inducer Motor		12/30/2003	662	24	27.5	24		42	15
16		Air Conditioner Condensing Unit		6/7/2004	2,300	329	7	329		439	16
17		Concerte Slab		7/29/2004	1,450	242	7	242		242	17
18		Road Repair		2/16/2005	1,263	171	7	171		109	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 15,070	\$ 1,113		\$ 1,113	\$	\$ 3,067	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 16,647	\$ 2,792	\$ 2,792	\$	5/7	\$ 11,750	71
72	Current Year Purchases	1,869	191	191		7	191	72
73	Fully Depreciated Assets	10,064				7	10,064	73
74								74
75	TOTALS	\$ 28,580	\$ 2,983	\$ 2,983	\$		\$ 22,005	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Employee Transportation	Pontiac Grand Am	2001	\$ 10,999	\$ 1,741	\$ 1,741		5	\$ 10,999	76
77	Patient Transportation	2004 Ford E250 Van	2004	41,786	8,357	8,357		5	11,839	77
78										78
79										79
80	TOTALS			\$ 52,785	\$ 10,098	\$ 10,098	\$		\$ 22,838	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 96,435	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,194	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 14,194	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 47,910	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Milestone Midwest, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1995</u>	<u>16</u>		\$ <u>92,760</u>	<u>15</u>	<u>15</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>16</u>		\$ <u>92,760</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 300

Description: Fax & Copier Lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 12/01/95

Ending 11/30/10

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 9/30/2006 \$ 92,760

13. 9/30/2007 \$ 92,760

14. 9/30/2008 \$ 92,760

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER CNA <u>40</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER CNA <u>80</u>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract		Total	
1	Community College Tuition	\$		\$		\$	
2	Books and Supplies						
3	Classroom Wages (a)		3,168			3,168	
4	Clinical Wages (b)		6,336			6,336	
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	CNA Competency Tests						
9	TOTALS	\$	9,504	\$		9,504	
10	SUM OF line 9, col. 1 and 2 (e)	\$	9,504				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ None

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$		1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	173,123		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 173,123	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	15,070		15
16	Equipment, at Historical Cost	81,365		16
17	Accumulated Depreciation (book methods)	(47,910)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 48,525	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 221,648	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	5,428		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,790		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 21,218	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	22,988		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 22,988	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 44,206	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 177,442	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 221,648	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 165,133	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 165,133	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	46,560	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 46,560	17
	B. Transfers (Itemize):		
18	Transfers (to) from Specialized Developments, Ltd.	(34,251)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (34,251)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 177,442	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 897,694	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 897,694	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 897,694	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	176,030	31
32	Health Care	228,950	32
33	General Administration	260,218	33
B. Capital Expense			
34	Ownership	128,276	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	54,310	36
D. Other Expenses (specify):			
37	<u>IL Repl Tax</u>	3,350	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 851,134	40
41	Income before Income Taxes (line 30 minus line 40)**	46,560	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 46,560	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Tax return is on a 12/31 fiscal year and is on the cash basis.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Burnham House# 0041327Report Period Beginning: 10/01/04Ending: 09/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	960	960	9,504	9.90	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,190	2,190	20,512	9.37	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,982	2,153	24,730	11.49	14
15	Cook Helpers/Assistants	1,825	1,825	17,093	9.37	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,920	2,920	27,349	9.37	18
19	Laundry	2,555	2,555	23,930	9.37	19
20	Administrator	2,752	3,085	40,247	13.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,460	1,460	13,674	9.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,016	1,105	16,364	14.81	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	10,863	12,794	119,312	9.33	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	28,523	31,047	\$ 312,715 *	\$ 10.07	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 3,992	1-3	35
36	Medical Director		5,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant		25,186	10-3	38
39	Pharmacist Consultant		240	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant		2,531	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		3,148	10-3	43
44	Activity Consultant				44
45	Social Service Consultant		2,450	12-3	45
46	Other(specify) <u>COTA</u>		4,440	10-3	46
47	<u>Psychologist</u>		1,610	10-3	47
48	<u>Dentist</u>		2,598	10-3	48
49	TOTAL (lines 35 - 48)		\$ 51,595		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Eric Edquist	50% Admin	None	\$ 16,363	Workers' Compensation Insurance	\$	8,228	IDPH License Fee	\$
Kandi Spann	Admin	None	22,745	Unemployment Compensation Insurance		12,127	Advertising: Employee Recruitment	378
Melissa McDaniel	Admin	None	1,139	FICA Taxes		23,923	Health Care Worker Background Check	
				Employee Health Insurance		6,589	(Indicate # of checks performed 7)	132
				Employee Meals		5,057	Dues & Subscriptions	2,879
				Illinois Municipal Retirement Fund (IMRF)*				
				Other		4,364		
				Schedule VIII Allocation		14,832	Schedule VIII Allocation	374
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 40,247					
B. Administrative - Other								
Description			Amount				Less: Public Relations Expense	()
Management Support & Consulting			\$ 102,766				Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 102,766	TOTAL (agree to Schedule V,	\$	75,120	TOTAL (agree to Sch. V,	\$ 3,763
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Martin, Hood, Friese & Assoc.	Accounting		\$ 6,060	None			Out-of-State Travel	\$
Various	Various		1,509					
Thomas, Mamer, & Haughey	Legal		70				In-State Travel	
Schiff, Hardin & Waite	Legal		2,282				Shcedule VIII Allocation	2,335
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 9,921				line 24, col. 8)	\$ 2,335

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Burnham House

STATE OF ILLINOIS

0041327

Report Period Beginning:

10/01/04

Ending:

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09/30/05

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IARF - \$956
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5/7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,310
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 5,057 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? Attached
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? None
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? None
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.